General Information for Authorization

Org	1. **506**		Service Type	2. **BS**

Client Information

Name	3. **client's name**	Client ID	4. **client ID**
Living Arrangements	5. **home**	Reference Auth #	6. **NA**

Provider Information

Requesting NPI #	7. **NPI**	Requesting Fax #	8.
Servicing NPI #	9. **NPI**	Name	10. **Requestor**
Referring NPI #	11. **if one**	Referring Fax #	12.
Service Start Date:	13. **current**		14. **N/A**

Service Request Information

Description of service being requested:

15. **Bariatric Surgery**	16. **N/A**	17. **N/A**

18. Serial / NEA# **NA**   19. **NA**

20. Code Qualifier	21. National Code	22. Mod	23. # Units/Days Requested	24. $ Amount Requested	25. Part # (DME Only)	26. Tooth or Quad #
C	**43845 or**		**1**		**NPI of who will provide**	
C	**43647 or**		**1**		**NPI of who will provide**	
C	**43648 or**		**1**		**NPI of who will provide**	
C	**43659 or**		**1**		**NPI of who will provide**	
C	**43770 or**		**1**			
C	**43771 or**		**1**			
C	**43772 or**		**1**			
C	**43773 or**		**1**			
C	**43774 or**		**1**			
C	**43842-43848**		**1**		**Only use 1 code in box21**	

Medical Information

Diagnosis Code	27. **278.01**	Diagnosis name	28. **Obesity and other applicable dx.**
Place of service	29. **21**		

30. Comments:

DSHS 13-835 (REV. 01/2010)

Instructions to fill out the General Information for Authorization form, DSHS 13-835

FIELD	NAME	ACTION
		ALL FIELDS MUST BE TYPED.
1	Org required	Enter the Number that Matches the Program/Unit for the Request 500 - Division of Alcohol and Substance Abuse (DASA) 501 - Dental 502 - Durable Medical Equipment (DME) 509 - Economic Services Administration (ESA) (DSHS) 504 - Home Health 505 - Hospice 506 - Inpatient Hospital 507 - Juvenile Rehabilitation Administration (JRA) (DSHS) 508 - Medical 509 - Medical Nutrition 510 - Mental Health 511 - Outpt Proc/Diag 513 - Physical Medicine & Rehabilitation (PM & R) 514 - Aging and Disability Services Administration (ADSA) 515 - Transportation 516 - Miscellaneous
2	Service Type required	Enter the letter(s) in all CAPS that represent the service type you are requesting.

Service Type codes (Field 2):

Code	Description	Code	Description
AA	Ambulatory Aids	OS	Orthopedic Shoes
BB	Bath Bench	OTC	Orthotics
BEM	Bath Equipment (misc)	PAS	PAS
BGM	Blood Glucose Monitors	PDN	
BGS	Bone Growth Stimulator		Private Duty Nursing
BP	Breast Pumps	PHY	Pharmacy
BS	Bariatric surgery	PL	Patient Lifts
BSS2	Bariatric surgery stage 2	PMR	PM and R
C	Commode	PROS	Prosthetics
CI	Cochlear Implants	PRS	Prone Standers
CIERP	Cochlear Implant Ext Repl Prts	PSY	Psychotherapy
CSC	Commode/Shower Chair	PTL	Partial
CWN	Crowns	PWH	Power Wheelchair - Home
DASA	DASA	PWNF	Power Wheelchair – NF
DEN	Dentures	PWNF	Power Wheelchair - NF
EN	Enteral Nutrition	PHYS	Physician Services
ESA	ESA	R	Respiratory
FSFS	Floor Sitter/Feeder Seat	RBS	Rebases
HB	Hospital Beds	RE	Room equipment
HEA	Hearing Aids	RLNS	Relines
HH	Home Health	RM	Readmission
HSPC	Hospice	S	Surgery
IPT	Infusion/Parental Therapy	SBS	Specialty Beds/Surfaces
ITA	Inpatient admission - ITA	SC	Shower chairs
JRA	JRA	SCAN	MRI/PET Scans
LTAC	LTAC	SF	Standing Frames
MC	Medication	SGD	Speech Generating Device
MISC	Miscellaneous	SSIP	Short Stay (In-Patient)
MN	Medical Nutrition	T	Therapies (PT/OT/ST)
MWH	Manual Wheelchair - Home	TRN	Transportation
MWNF	Manual Wheelchair - NF	TU	TENS Units
O	Other	US	Urinary Supplies
ODC	Orthodontic	V	Vision
ODME	Other DME	VNSS	Vagus nerve stimulator surgery
OOS	Out of State	VOL	Inpatient admission-Voluntary
OP	Ostomy Products	WDCS	Wound/decubiti care supplies

3	Name: Required.	Enter the last name, first name, and middle initial of the patient you are requesting authorization for.
4	Client ID: Required.	Enter the client ID = 9 numbers followed by WA. For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending): ▪ You will need to contact DSHS at 1-800-562-3022 and the appropriate extension of the Authorization Unit (See contact section for further instructions). ▪ A reference PA will be built with a placeholder client ID. ▪ If the PA is approved – once the client ID is known – you will need to contact DSHS either by fax or phone with the Client ID. ▪ The PA will be updated and you will be able to bill the services approved.
5	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc.
6	Reference Auth #	If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI #: Required.	The 10 digit numeric number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#	The fax number of the requesting provider.
9	Servicing NPI #: Required.	The 10 digit numeric number that has been assigned to the billing/servicing provider by CMS.
10	Name	The name of the billing/servicing provider.
11	Referring NPI #	The 10 digit numeric number that has been assigned to the referring provider by CMS.
12	Referring Fax #	The fax number of the referring provider.
13	Service Start Date	The date the service is planned to be started if known.
15	Description of service being requested: Required.	A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).
18	Serial/NEA#: Required for all DME repairs.	Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA# to access the x-rays for this request.
20	Code Qualifier: Required.	Enter the letter corresponding to the code from below: T - CDT Proc Code C - CPT Proc Code D - DRG P - HCPCS Proc Code I - ICD-9/10 Proc Code R - Rev Code N - NDC-National Drug Code S - ICD-9/10 Diagnosis Code
21	National Code: Required.	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier	When appropriate enter a modifier.
23	# Units/Days Requested: Required.	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific Billing Instructions for the appropriate unit/day designation for the service code entered).
24	$ Amount Requested: Required.	Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Billing Instructions and fee schedules for assistance) Must be entered in dollars & cents with a decimal (e.g. $400 should be entered as 400.00.
25	Part # (DME only): Required for all "By Report" codes requested.	Enter the manufacturer part # of the item requested.

26	Tooth or Quad#: Required for dental requests	Enter the tooth or quad number as listed below: QUAD 00 – full mouth 01 – upper arch 02 – lower arch 10 – upper right quadrant 20 – upper left quadrant 30 – lower left quadrant 40 – lower right quadrant Tooth # 1-36, A-T, AS-TS, 51-82 and SN
27	Diagnosis Code	Enter appropriate diagnosis code for condition.
28	Diagnosis name	Short description of the diagnosis.
29	Place of Service	Enter the appropriate two digit place of service code.
30	Comments	Enter any free form information you deem necessary.